

Focus: current issues in medical ethics

Triage and the patient with renal failure

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Authors' abstract

The call for 'triage' as a specific policy for the selection of patients presenting with chronic renal failure, in the light of increasingly limited resources prompted us to question nephrologists on their bases for selection. We discovered no absolute criteria for rejection, but a consensus of opinion against those with additional and complicating factors to their renal disease such as age, hepatitis carriers and mental illness - a bias seen throughout the National Health Service. In this paper we discuss the validity of such criteria, the implications of the currently pragmatic and often covert practice of selection, and in this potentially finite area of demand we question the rationale for the limitation of resources.

Introduction

The term 'triage' originally meant the action of sorting according to quality, but has developed in American usage to refer particularly to the battle situation where victims are sorted according to a system of priorities designed to maximise the number of survivors.¹⁻³ Casualties are sorted according to the severity of their injuries and their fitness to return to battle, maximum effort being expended on those likely to be able to fight again, while those with severe prognoses may receive minimum treatment. In the accident and emergency situation triage still applies and greatly assists the allocation of priorities in treatment, preventing overcrowding.³ The same process has now been suggested for patients suffering from renal failure,⁴ where limited resources and facilities for treatment may be exhausted before the end of a financial year, and the chance of a patient receiving treatment could depend on the time of presentation.

This has occurred in our own Health District over the last year, and for transplantation to continue for the last three months of the financial year support had to be accepted from charitable services in the absence of Health Service funds. The response of the administration to the evident inequality of the treatment of patients according to time of presentation was the suggestion that selection of patients

must take place throughout the year in order to maximise limited resources. A strict policy of selection had not operated in our own area, and of over four hundred patients taken on for treatment in the last eleven years, the twenty-two patients we rejected had not been offered treatment in their own area and had complications in addition to their renal disease.

Rejection of patients has been recorded before, but has rarely been analysed or stated systematically. Our own series is shown alongside those of Northern Ireland⁵ and The London Hospital⁶ in Table 1.

Table 1: Patients who have been designated as unsuitable for treatment in three areas

	1969-72 London NE region	1968-70 NIreland Belfast	1970-79 London KCH
Patients included in survey	1260	222	458
'Unsuitable'	288 (23%)	46 (21%)	22 (5%)
Grounds given for rejection			
Psychosocial	67	17	4
Medical complications	123	15	8
Diabetes	20	14	6
Australia antigen +ve	4	—	2
Died waiting	74	—	2

Each of these categories cannot be regarded as an absolute reason for exclusion. Patients have been successfully treated with tuberculosis,⁷ diabetes,⁸ and australia antigen disease,⁹ and even age has not been an absolute bar.¹⁰ In view of the uncertainty of the basis of rejection we thought it necessary to obtain a possible consensus among British nephrologists as to their grounds for selection and rejection of patients.

Method

A list of forty male and female patients with a variety of ages, social and marital status, a main disease causing their renal failure and in some cases an additional complicating disease were brought together from our own experience. Each had a basis

Table II: The ten most frequently rejected patients out of the forty listed, and the reasons given for this rejection

Patient no.	Units rejecting	Age	Marital status	Home facilities	Accompanying disease	Underlying disease
20	22	—	2	7	22	—
37	19	—	—	4	19	—
27	19	—	3	4	16	—
25	19	15	4	10	3	5
18	17	1	1	4	17	—
2	17	—	—	1	16	—
34	18	—	3	8	18	—
3	16	—	1	1	7	11
24	15	—	4	8	15	6
5	12	12	—	—	—	—

Table III: Reasons given for rejection (AA+ve=australia antigen carrier)

Patient no.	Main reasons in order of importance
20	Schizophrenia, single status, poor home facilities
37	AA+ve, poor home facilities
27	AA+ve, poor home facilities
25	Age (60), poor home facilities, marital status
18	Drug Addict (risk of AA+ve), poor home facilities
2	AA+ve
34	Long stay mental patient, ill health
3	Blind diabetic
24	Paraplegic, poor home facilities, marital status
5	Age (68) alone

in real clinical practice. The physicians in renal units consulted were asked to reject ten out of the forty and to state their reasons on a check list under the categories of age, marital status, home facilities, underlying disease and the accompanying disease (including diabetes and australia antigen disease).

The importance of the selection issue to the nephrologists approached was reflected in the response (25/25). Many wrote long qualifying letters expressing their anxiety and explaining their rejections as being due to local policy decisions regarding transplantation, and stressing the possibility of alternative forms of treatment to recognised haemodialysis and transplantation, namely technical advances in home dialysis and continuous ambulatory peritoneal dialysis. Only one physician felt unable to reject any of the patients suggested on medical grounds and was therefore unable to complete the check list.

Results

Only thirteen patients out of the forty, *ie* one third, stood the chance of being accepted in all the units questioned; on the other hand no single

patient in the series was rejected by all unit physicians. When we came to analyse the ten patients most frequently rejected, we found that at least six of them had been successfully treated by our own unit.

Discussion

The main reason for rejection was on the grounds of accompanying disease, where the treatment of renal failure will not alleviate the complications and the suffering already sustained. Interestingly enough the majority of units rejected a young homeless schizophrenic with long-standing chronic mental illness, a patient we had also rejected for treatment some years ago, before evidence was accumulating that the occasional patient's mental symptoms may be alleviated by dialysis therapy.¹¹ Of the next nine patients rejected by half the units consulted, three had australia antigen in their blood and a further patient, a drug addict, had the risk of contracting the disease. Age and other disabilities characterised the other patients rejected, and these will be discussed below.

In at least half the patients rejected, poor home facilities for dialysis made rejection more likely. This reflects the high preference for home renal dialysis therapy in the United Kingdom where there is the highest number of patients per million in Europe.¹² Without this outlet many units would 'silt' up and be unable to accept further patients. Discrimination on social grounds is never an absolute criterion, permitting as it can the individual prejudices of the physician, but it is obviously an additional weight in the scales when competing demands exist.

THE PREVALENCE OF AUSTRALIA ANTIGEN CARRIERS

It is worrying to note that all the patients of our original forty who had australia antigen in their blood were rejected by over half the units questioned. The reasons why these patients, who would otherwise be acceptable, were rejected is that they have to be treated in a different area from other patients, in what is often designated a 'yellow' unit or area. The

experience of units who did not take this extra precaution is that they risked their patients and staff developing occasionally lethal hepatitis.¹³ Where this has occurred the only solution is to close the unit until all the highly infective patients are either transplanted or moved to home dialysis, inevitably preventing the treatment of non-infected patients during this time.¹⁴ The risk of closure may be deemed too great to allow the treatment of patients known to be carriers, or those likely to develop it, such as drug addicts (patient 18), and these patients may be sacrificed in favour of the remainder.¹⁵ The Rosenheim Report¹⁶ suggested the segregation of such patients in special areas so that they could be treated by a separate team of nurses and possibly physicians and surgeons, so that a risk of cross infection could be minimised. The development of such costly segregation has only been provided in a few areas but some AA +ve patients have survived for longer following transplantation than AA -ve patients, while others may go slowly to a more aggressive form of hepatic disease.⁹ Ultimately, the rejection of these patients may depend on lack of resources for their segregated care, rather than on purely medical grounds.

DIABETES AND OTHER DISABLING DISEASES

Blindness, poor vessels, paralysed limbs all make dialysis more difficult. Age exclusions may often be on the basis of progressive vascular disease which leads to increasing complications. The break point is often between what the patient can tolerate and what the staff who care for the patient can carry, and both parties have the option of stopping treatment.¹⁷ Where the wish to stop treatment is on the grounds that resources are being drained by the heavily handicapped and homeless from other less demanding patients transplantation offers a solution, and this is one we favour for the diabetic. Of the two paraplegics we treated in this way, one died months afterwards and the other is still alive (patient 14) three years later.

Conclusions

We found no absolute grounds for the rejection of any patient wishing to undergo treatment - no single patient was rejected by all the physicians questioned. There is a consensus of opinion however which finds certain groups of patients more difficult to accept: those with severe mental illness, with infectious disease or considerable physical handicap comprising widespread complications of simple ageing alone. These are the groups who, even without renal disease, tend to do badly in terms of resource allocation in the National Health Service.

As a technical speciality which uses expensive equipment renal medicine has been seen as a questionable drain on health service funds, although some researchers query whether 'small ticket'

technology such as routine blood testing is not a greater drain.¹⁸ However, with an accepted figure of 40 per million¹⁹ presenting each year with renal failure the number of people requiring treatment for renal disease is potentially finite, and with proper planning, once a large enough pool is established the natural loss of patients each year would equal those presenting.⁶ Ultimately, preventive measures against the common causes of glomerulonephritis and pyelonephritis may reduce demand and realise the expenditure on research over the years in this area.

As long as the restrictive limitation of resources persists for this speciality rejection of patients will continue. The United Kingdom already trails behind Europe in the treatment of older patients, with those over sixty-five being five times less likely to be treated here as abroad,²⁰ but a universally acceptable and non-arbitrary basis for selection has not emerged. Application of selection policies based on the patient's prospective ability to repay a portion of costs via taxation is unrealistic and inhumane and moreover does not occur in other medical areas such as oncology or geriatric care.²¹ Facing up to the lack of resources available to provide the ideal form of treatment physicians are responding by using less expensive forms such as peritoneal dialysis, continuous ambulatory peritoneal dialysis (CAPD) and extending home dialysis facilities to delay outright rejection.

One of the most worrying features is the extent to which patients may be unaware of the choice of treatment available, or indeed of the availability of treatment at all. A recent state law enacted in Massachusetts, whose premise is that all patients are entitled to quality health care as a right, makes the physician responsible for informing the patient fully about the choices of treatment available for carcinoma of the breast, and for discussing the merits of these choices.²² The extension of such rights to patients suffering from end-stage renal failure would indicate to a large group of patients the possible forms of treatment withheld on the grounds of economy, and enable them to seek treatment in less restrictive units, or to use political pressure, for example via patients' associations.

The disturbing feature of this enquiry is the extent to which physicians' professional expertise and position of trust is being used to translate economic and political decisions into the selection of patients, without those presenting with renal disease, their relatives or the public necessarily being aware of this process. It is highly questionable whether this is an ethical deployment of the physicians' skills, and it is preferable as de Wardener has recently stated for physicians to be overruled by the administration than for the present coercion into compliance to continue.²³

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